DSS-OS-950 02/08

TITLE XIX MEDICAL TRANSPORTATION REIMBURSEMENT FORM

–To Be Returned After Your Trip –

Medicaid Recipient's Name	Date of Birth	Medicaid #

(If there are additional family members that traveled and had a medical appointment, please list them on the back of the sheet.)

Recipient Address _____

Phone # _____

Payment Goes To _____

Address _____

Phone # _____

Appointment Date _____ **Appointment Time** _____

Origin (city) _____ **Destination (city)** _____

Departure Date _____ **Time** _____ **Return Date** _____ **Time** _____

Lodging: Please list specific days/times on the reverse for both the recipient and escort for accurate reimbursement.
Recipient: ☐ Motel (receipt required) ☐ Family/Friend (no receipt required) ☐ Inpatient Hospital Stay (no receipt required)
Driver/Escort: ☐ Motel (receipt required) ☐ Family/Friend (no receipt required) ☐ Stayed at Hospital (no receipt required)

Have you received any assistance from another source to help with this trip? ☐ YES ☐ NO
If yes, who? _____ Amount: $ _____

To be filled out by the Medical Provider

Name of Medical Facility: _____

Address and Phone Number: _____

Name of Doctor: _____ Service NPI #: _____

Type of Provider (GP, Cardiologist, Dentist, etc.): _____

Purpose of visit: _____

Is this a Medicaid covered service? ☐ Yes ☐ No
Did this service require prior authorization by Medicaid? ☐ Yes ☐ No
Was the patient hospitalized? ☐ Yes ☐ No If yes, please list admit/discharge dates _____

Signature: _____ **Date:** _____
(Receptionist, Nurse, or Doctor Signature)

- Mileage will be reimbursed according to established program guidelines.
- Travel to your primary care provider will ***not*** be reimbursed.
- Travel to a medical provider within your city limits will ***not*** be reimbursed.
- A motel receipt is required for lodging reimbursement for a driver and/or the recipient (maximum of 2).
- Meals will be reimbursed only if the medical appointment requires an overnight stay.
- Recipient only: During an inpatient hospital stay meals and lodging will ***not*** be reimbursed.

- I understand that I will be paid mileage only to the **closest provider capable of providing the necessary services**.

- I certify that the above information is correct to the best of my knowledge and the attached receipts, if any, represent eligible expenses.

SIGNATURE _____ **Date** _____
(Recipient, parent, or guardian)

Please return this form, along with any necessary referrals or receipts, to:

Dept. of Social Services
Finance/EBT
700 Governors Drive
Pierre SD 57501

Fax Number: (605) 773-8461
Toll Free Number: 866-403-1433
Local Phone Number: (605) 773-6527

NOTE: There are penalties for fraudulently submitting claims for reimbursement and misrepresentation of receipts submitted for payment.